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Mental and Behavioural Disorders

Preventing Suicide: a resource for teachers and other school staff

Department of Mental Health
Social Change and Mental Health
World Health Organization
Geneva

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PREVENTING SUICIDE
A RESOURCE FOR TEACHERS AND OTHER SCHOOL STAFF

This document is one of a series of resources addressed to specific social and professional groups particularly relevant to the prevention of suicide.

It has been prepared as part of SUPRE, the WHO worldwide initiative for the prevention of suicide.

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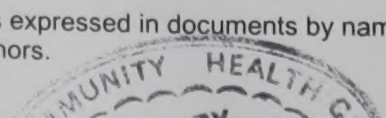

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FOREWORD

Suicide is a complex phenomenon that has attracted the attention of philosophers, theologians, physicians, sociologists and artists over the centuries; according to the French philosopher Albert Camus, in *The Myth of Sisyphus*, it is the only serious philosophical problem.

As a serious public health problem it demands our attention, but its prevention and control, unfortunately, are no easy task. State-of-the-art research indicates that the prevention of suicide, while feasible, involves a whole series of activities, ranging from the provision of the best possible conditions for bringing up our children and youth, through the effective treatment of mental disorders, to the environmental control of risk factors. Appropriate dissemination of information and awareness-raising are essential elements in the success of suicide prevention programmes.

In 1999 WHO launched SUPRE, its worldwide initiative for the prevention of suicide. This booklet is one of a series of resources prepared as part of SUPRE and addressed to specific social and professional groups that are particularly relevant to the prevention of suicide. It represents a link in a long and diversified chain involving a wide range of people and groups, including health professionals, educators, social agencies, governments, legislators, social communicators, law enforcers, families and communities.

We are particularly indebted to Professor Danuta Wasserman, Professor of Psychiatry and Suicidology, and Dr Veronique Narboni, of the National Swedish and Stockholm County Centre for Suicide Research and Prevention of Mental Ill-Health, WHO Collaborating Centre, who produced an earlier version of this booklet. The text was subsequently reviewed by the following members of the WHO International Network for Suicide Prevention, to whom we are grateful:

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The resources are now being widely disseminated, in the hope that they will be translated and adapted to local conditions - a prerequisite for their effectiveness. Comments and requests for permission to translate and adapt them will be welcome.

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PREVENTING SUICIDE
A RESOURCE FOR TEACHERS AND OTHER SCHOOL STAFF

Worldwide, suicide is among the top five causes of mortality in the 15- to 19- year age group. In many countries it ranks first or second as a cause of death among both boys and girls in this age group.

Suicide prevention among children and adolescents is therefore a high priority. Given the fact that in many countries and regions most people in this age group attend school, this appears to be an excellent place to develop appropriate preventive action.

This document is primarily aimed at schoolteachers and other school staff, such as school counsellors, school doctors, nurses and social workers, and members of school boards of governors. However, public health professionals and other groups interested in suicide prevention programmes will also find the information provided useful. The document briefly describes the dimension of suicidal behaviour in adolescence, presents the main protective and risk factors behind this behaviour, and indicates how to identify and manage individuals at risk and also how to act when suicide is attempted or committed in the school community.

Currently, suicide among children below the age of 15 years is generally uncommon. Most suicides among children aged up to 14 probably take place in early adolescence, while suicide is rarer still before the age of 12. However, in some countries there is an alarming increase in suicides among children aged less than 15, as well as in the 15- to 19- year age group.

Suicide methods vary between countries. In some countries, for example, the use of pesticides is a common suicide method, whereas in

others intoxication with medicines and car exhausts and the use of guns are more frequent. Boys die from suicide much more often than girls; one reason may be that they resort to violent methods of committing suicide, such as hanging, firearms and explosives, more frequently than girls. However, in some countries suicide is more frequent among girls aged 15-19 than among boys in the same age group, and over the past decade the proportion of girls using violent methods has risen.

Whenever feasible, the best approach to school-based suicide prevention activities is teamwork that includes teachers, school doctors, school nurses, school psychologists and school social workers, working in close cooperation with community agencies.

Having suicidal thoughts now and then is not abnormal. They are part of the normal development process in childhood and adolescence, as are working on existential problems and trying to understand life, death, and the meaning of life. Questionnaire surveys show that more than half of upper-secondary students report that they have entertained thoughts of suicide.[1] Young people need to discuss these topics with adults.[2]

Suicidal thoughts become abnormal in children and adolescents when the realization of those thoughts seems to be the only way out of their difficulties. There is then a serious risk of attempted suicide or suicide.

AN UNDERESTIMATED PROBLEM

In some cases, it may be impossible to ascertain whether some deaths,[3] caused for example by car crashes, drowning, falls and overdoses of illegal drugs, were unintentional or intentional. Adolescent suicidal behaviour is widely deemed to be underreported, because many deaths of this type are inaccurately classified as unintentional or accidental.

Postmortem studies of adolescents who died from violent causes indicate that they do not constitute a homogeneous group. They show subtle manifestations of self-destructive and risk-taking tendencies[4] and, while some of their deaths may be caused by unintentional acts, others are intentional acts resulting from the pain of living.

In addition, the definitions of attempted suicide used by students differ from those used by psychiatrists. Self-reported results show almost twice the number of suicide attempts revealed by psychiatric interviews. The most likely explanation is that the young people who responded to anonymous inquiries were using a broader definition of attempted suicide than that used by professionals. Moreover, only 50% of adolescents reporting that they had tried to kill themselves had sought hospital care after their suicide attempts. Thus, the number of suicide attempters treated in hospital is no real indication of the dimension of the problem in the community.

Generally speaking, adolescent boys commit suicide more often than girls do. Nevertheless, the rate of attempted suicide is two to three times higher among girls. Girls develop depression more often than boys do, but they also find it easier to talk about their problems and to seek assistance, and this probably helps to prevent fatal suicidal acts. Boys are often more aggressive and impulsive, and not infrequently act under the influence of alcohol and illicit drugs, which probably contributes to the fatal outcome of their suicidal acts.

PROTECTIVE FACTORS

Major factors that afford protection against suicidal behaviour are:

Family patterns

- good relationships with family members;
- support from family.

Cognitive style and personality

- good social skills;
- confidence in oneself and one's own situation and achievements;
- seeking help when difficulties arise, e.g. in school work:
- seeking advice when important choices must be made;
- openness to other people's experiences and solutions;
- openness to new knowledge.

Cultural and sociodemographic factors

- social integration, e.g. through participation in sport, church associations, clubs and other activities;
- good relationships with schoolmates;
- good relationships with teachers and other adults;
- support from relevant people.

RISK FACTORS AND RISK SITUATIONS

Suicidal behaviour under particular circumstances is more common in certain families than in others, owing to environmental and genetic factors. Analysis shows that all the factors and situations described below are frequently associated with attempted and completed suicide among children and adolescents, but it must be remembered that they are not necessarily present in every case.

It must also be remembered that the risk factors and risk situations described below vary from one continent and country to another, depending on cultural, political and economic features that differ even between neighbouring countries.

Cultural and sociodemographic factors

Low socioeconomic status, poor education and unemployment in the family are risk factors. Indigenous people and immigrants may be assigned to this group, since they often experience not only emotional and linguistic difficulties but also the lack of social networks. In many cases, these factors are combined with the psychological impact of torture, war injuries and isolation.

These cultural factors are also linked with low participation in society's customary activities, as well as with conflict between various group values. Specifically, this conflict is a powerful factor for girls born or brought up in a new and freer country, but who retain strong roots in their parents' even stronger conservative culture.

Each individual young person's growth is intertwined with collective cultural tradition. Children and adolescents who lack cultural roots have marked identity problems and lack a model for conflict resolution. In some stressful situations, they may resort to self-destructive behaviour such as a suicide attempt or suicide.[5]

There is a higher risk of suicidal behaviours in indigenous versus non-indigenous people.

The attributes of gender nonconformity and identity issues relating to sexual orientation are also risk factors for suicidal behaviours. Children and adolescents who are not openly accepted in their culture, by their families and peers, or by their schools and other institutions have serious acceptance problems and lack supportive models for optimum development.

Family pattern and negative life events during childhood

Destructive family patterns and traumatic events in early childhood affect young people's lives thereafter, especially when they have been unable to cope with the trauma.[6]

Aspects of family dysfunction and instability and negative life events often found in suicidal children and adolescents are:

- parental psychopathology,[7] with the presence of affective and other psychiatric disorders;
- alcohol and substance abuse, or antisocial behaviour in the family;
- a family history of suicide and suicide attempts;
- a violent and abusive family (including physical and sexual abuse of the child);
- poor care provided by parents/guardians, with poor communication within the family;
- frequent quarrels between parents/guardians, with tension and aggression;
- divorce, separation or death of parents/guardians;
- frequent moves to a different residential area;
- very high or very low expectations on the part of parents/guardians;
- parents'/guardians' inadequate or excessive authority;
- parents'/guardians' lack of time to observe and deal with the child's emotional distress, and a negative emotional environment featuring rejection or neglect;
- family rigidity;[8]
- adoptive or foster family.

These family patterns often, but by no means always, characterize cases of children and adolescents who attempt or commit suicide. Evidence suggests that young suicidal people often come from families with more than one problem in which risks are cumulative. Since they are loyal to their parents and sometimes unwilling, or forbidden, to reveal family secrets, they frequently refrain from seeking help outside the family.

Cognitive style and personality

The following personality traits are frequently observed during adolescence, but are also associated with the risk of attempted or completed suicide (often in conjunction with mental disorder), so that their utility in predicting suicide is limited:

- unstable mood;
- angry or aggressive behaviour;
- antisocial behaviour;
- acting-out behaviour;
- high impulsivity;
- irritability;
- rigid thinking and coping patterns;
- poor problem-solving ability when difficulties arise;
- an inability to grasp realities;
- a tendency to live in an illusory world;
- fantasies of greatness alternating with feelings of worthlessness;
- a ready sense of disappointment;

- anxiety, particularly at signs of mild physical ailment or minor disappointment;
- self-righteousness;
- feelings of inferiority and uncertainty that may be masked by overt manifestations of superiority, rejection or provocative behaviour towards schoolmates and adults, including parents;
- uncertainty concerning gender identity or sexual orientation;[9]
- ambivalent relationships with parents, other adults and friends.

While there is much interest in the relationships between the extensive array of personality and cognitive factors and risk of suicidal behaviour in young people, the available research evidence for any specific trait is generally sparse and often equivocal.

Psychiatric disorders

Suicidal behaviour is overrepresented in children and adolescents with the following psychiatric disorders.

Depression

The combination of depressive symptoms and antisocial behaviour has been described as the most common antecedent of teenage suicide.[10,11] Several surveys have established that up to three-quarters of those who eventually take their own lives show one or more symptoms of depression, and many suffer from a full-blown depressive illness.[12]

School students suffering from depression often present physical symptoms when they seek medical advice.[13] Somatic complaints, such as headache and stomach-ache and also shooting pains in the legs or chest, are frequent.

Depressed girls have strong tendencies to withdraw and become silent, despondent and inactive. Depressed boys tend, instead, towards disruptive and aggressive behaviour and demand a great deal of attention from their teachers and parents. Aggressiveness can lead to loneliness, which is in itself a risk factor for suicidal behaviour.

Although some depressive symptoms or depressive disorders are common among suicidal children, depression is not a necessary concomitant of either suicidal thoughts or suicide attempts.[14] Adolescents can kill themselves without being depressed, and they can be depressed without killing themselves.

Anxiety disorders

Studies have shown a consistent correlation between anxiety disorders and suicide attempts in males, while a weaker association has been found in females. Trait anxiety appears to be relatively independent of depression in its effect on the risk of suicidal behaviour, which suggests that the anxiety of adolescents at risk for suicidal behaviour should be assessed and treated. Psychosomatic symptoms are also often present in young persons tormented by suicidal thoughts.

Alcohol and drug abuse

Abusers of alcohol and illicit drugs are overrepresented among children and adolescents who commit suicide. In this age group, one in four suicidal patients has been found to have consumed alcohol or drugs before the act.[15]

Eating disorders

Owing to dissatisfaction with their bodies, many children and adolescents try to lose weight and are concerned about what they should and should not eat. Between 1% and 2% of teenage girls suffer from either anorexia or bulimia. Anorexic girls very frequently also succumb

to depression, and suicide risk among anorexic girls is 20 times that for young people in general. Recent findings show that boys, too, can suffer from anorexia and bulimia. [13,17]

Psychotic disorders

Although few children and adolescents suffer from severe psychiatric disorders such as schizophrenia or manic-depressive disorder, suicide risk is very high in those affected. Most psychotic young people are, in fact, characterized by several risk factors, such as drinking problems, excessive smoking and drug abuse.

Previous suicide attempts

A history of single or recurrent suicide attempts, with or without the above-mentioned psychiatric disorders, is an important risk factor for suicidal behaviour.

Current negative life events as triggers of suicidal behaviour

A marked susceptibility to stress, with the cognitive style and personality traits mentioned above (due to inherited genetic factors but also to family patterns and negative life stressors experienced in early life), is usually observed in suicidal children and adolescents.[16] This susceptibility makes it difficult to cope with negative life events adequately, and suicidal behaviour is therefore often preceded by stressful life events. They reactivate the sense of helplessness, hopelessness and despair that may bring thoughts of suicide to the surface and lead to attempted suicide or suicide.[17]

Risk situations and events that may trigger suicide attempts or suicide are:

- situations that may be experienced as injurious (without necessarily being so when evaluated objectively): vulnerable children and adolescents may perceive even trivial occurrences

as deeply injurious and react with anxiety and chaotic behaviour, while suicidal young people perceive such situations as threats directed against their self-image and suffer from a sense of wounded personal dignity;

- family disturbances;
- separation from friends, girl-/boyfriends, classmates, etc.;
- death of a loved one or other significant person;
- termination of a love relationship;
- interpersonal conflicts or losses;
- legal or disciplinary problems;
- peer-group pressure or self-destructive peer acceptance;
- bullying and victimization;
- disappointment with school results and failure in studies;
- high demands at school during examination periods;
- unemployment and poor finances;
- unwanted pregnancy, abortion;
- infection with HIV or other sexually transmitted diseases;
- serious physical illness;
- natural disasters.

HOW TO IDENTIFY STUDENTS IN DISTRESS AND AT POSSIBLE RISK OF SUICIDE

Identification of distress

Any sudden or dramatic change affecting a child's or adolescent's performance, attendance or behaviour should be taken seriously,[18] such as:

- lack of interest in usual activities;
- an overall decline in grades;
- decrease in effort;
- misconduct in the classroom;
- unexplained or repeated absence or truancy;
- excessive tobacco smoking or drinking, or drug (including cannabis) misuse;
- incidents leading to police involvement and student violence.

These factors help to identify school students at risk of mental and social distress who may have thoughts of suicide that ultimately lead to suicidal behaviour.[19]

If any of these signs are identified by a teacher or school counsellor, the school team should be alerted and arrangements should be made to carry out a thorough evaluation of the student, since they usually indicate severe distress and the outcome may, in some cases, be suicidal behaviour.

Assessment of suicide risk

When assessing suicide risk, school staff should be aware that problems are always multidimensional.

Previous suicide attempts

A history of previous suicide attempts is one of the most significant risk factors. Young people in distress tend to repeat their acts.

Depression

Another major risk factor is depression. The diagnosis of depression should be made by a physician or child/adolescent psychiatrist, but teachers and other school staff should be aware of the variety of symptoms[20] that form part of depressive illness.[21]

The difficulty of assessing depression is linked to the fact that the natural transitional stages of adolescence share some features with depression.

Adolescence is a normal state, and during its course such features as low self-esteem, despondency, concentration problems, fatigue and sleep disturbances are common. These are also common features of depressive illness, but there is no cause for alarm unless they are lasting and increasingly severe. Compared with depressed adults, the young tend to act out, eat and sleep more.

Depressive thoughts may be present normally in adolescence and reflect the normal development process, when the young person is preoccupied with existential issues. The intensity of suicidal thoughts, their depth and duration, the context in which they arise and the impossibility of distracting a child or adolescent from these thoughts (i.e. their persistence) are what distinguishes a healthy young person from one in the throes of a suicidal crisis.

Risk situations

Another important task is to identify environmental situations and negative life events, as outlined previously, that activate suicidal thoughts and thus increase suicide risk.

HOW SHOULD SUICIDAL STUDENTS BE MANAGED AT SCHOOL?

Recognizing a young person in distress, who needs help, is not usually much of a problem. Knowing how to react and respond to suicidal children and adolescents is much more difficult.

Some school staff have learnt how to treat distressed and suicidal students with sensitivity and respect, while others do not. The latter group's skills should be improved. The balance that must be struck in the contact with a suicidal student is one between distance and closeness, and between empathy and respect.

The recognition and management of suicidal crises in students may give rise to conflict in teachers and other school staff since they lack the specific skills required, are short of time, or fear facing their own psychological problems.

General prevention: before any suicidal act takes place

The most important aspect of any suicide prevention is early recognition of children and adolescents in distress and/or at increased risk of suicide.[22] To achieve this goal, particular emphasis should be laid on the situation of the school staff and students concerned, by the means described below. Many experts share the view that it is unwise to teach young people about suicide explicitly. Rather, they recommend that issues relating to suicide are replaced by a positive mental health approach.

Strengthening the mental health of schoolteachers and other school staff[23]

First of all, it is essential to secure the well-being and balance of teachers and other school staff. For them, the workplace may be rejecting, aggressive and sometimes even violent. Therefore they need information material that enhances their understanding and proposes

adequate reactions to their own, students' and colleagues' mental strain and possible mental illness. They should also have access to support and, if necessary, treatment.

Strengthening students' self-esteem[24]

Positive self-esteem protects children and adolescents against mental distress and despondency, and enables them to cope adequately with difficult and stressful life situations.[25]

To foster positive self-esteem in children and adolescents a variety of techniques can be used. Some recommended approaches follow:

- Positive life experiences that will help to forge a positive identity[26] in the young should be accentuated. Positive past experiences increase young people's chances of greater future self-confidence.
- Children and adolescents should not be constantly pressured to do more and better.
- It is not enough for adults to say they love the child; the child must feel loved. There is a big difference between being loved and feeling loved.
- Children should not only be accepted, but also cherished, as they are. They must feel special just because they exist.

Whereas sympathy impedes self-esteem, empathy fosters it, because judgement is set aside. Autonomy and mastery are building-blocks in the development of positive self-esteem in early childhood.

Children's and adolescents' achievement of self-esteem is dependent on their development of physical, social and vocational skills. For high self-esteem, the teenager needs to establish final

independence from family and age mates; be able to relate to the opposite sex; prepare for an occupation for self-support; and establish a workable and meaningful philosophy of life.

Introducing training in life skills, first by visiting experts and later as part of the regular curriculum, is an effective strategy. The programme should convey knowledge to peers on how to be supportive and, if necessary, seek adult help.

The education system should also enhance the development and consolidation of every student's sense of identity.

Promoting the stability and continuity of students' schooling is another important aim.

Promoting emotional expression

Children and adolescents should be taught to take their own feelings seriously and encouraged to confide in parents and other adults, such as teachers, school doctors or nurses, friends, sport coaches, and religious advisers.

Preventing bullying and violence at school

Specific skills should be available in the education system to prevent bullying and violence in and around the school premises in order to create a safe environment free of intolerance.

Providing information about care services

The availability of specific services should be ensured by widely publicizing the telephone numbers of, for example, crisis and emergency helplines and psychiatric emergency numbers, and making them accessible to young people.

Intervention: when a suicide risk is identified

In most cases, children and adolescents in distress and/or at risk of suicidal behaviour also experience communication problems. Consequently, it is important to establish a dialogue with a distressed and/or suicidal young person.

Communication

The first step in suicide prevention is invariably a trustful communication. During the development of the suicidal process, mutual communication between suicidal young people and those around them is crucially important. Lack of communication and the broken network that ensues result in:

- Silence and increased tension in the relationship. The adult's fear of provoking the child or adolescent into committing a suicidal act by discussing his or her suicidal thoughts and messages is often the reason for the silence and absence of dialogue.

- Obvious ambivalence. Understandably, adults' confrontation with a child or adolescent suicidal communication brings their own psychic conflicts to the fore. The psychological strain of an encounter with a distressed and/or suicidal child or adolescent is usually very heavy, and involves a wide range of emotional reactions. In some cases, the unsolved emotional problems of adults who are in contact with suicidal children and adolescents may come to the surface. Such problems may be accentuated among school staff, whose ambivalence - wanting, but simultaneously being unwilling or unable, to help the suicidal student - may result in avoidance of dialogue.

- Direct or indirect aggression. Adults' discomfort is sometimes so great that their ultimate reaction to the child or adolescent who is in distress or suicidal is one of verbal or non-verbal aggression.

- It is important to understand that the teacher is not alone in this communication process, and learning how to achieve good communication is therefore fundamental. The dialogue should be created in and adapted to each situation. Dialogue implies, first and foremost, recognition of children's and adolescents' identity and also their need for help.

Children and adolescents in distress or at risk of suicide are often hypersensitive to other people's style of communication most of the time. This is because they have often lacked trustful relationships with their families and peers during their upbringing, and so have experienced an absence of interest, respect or even love. The suicidal student's hypersensitivity is apparent in verbal and non-verbal communication alike. Here, body language plays as large a role as verbal communication. However, adults should not be discouraged by distressed and/or suicidal children's or adolescents' reluctance to speak to them. Instead, they should remember that this attitude of avoidance is often a sign of distrust of adults.

Suicidal children and adolescents also display marked ambivalence about whether to accept or reject help that is offered, and about whether to live or die. This ambivalence has evident repercussions on the suicidal young person's behaviour, which can show rapid changes from help-seeking to rejection and may easily be misinterpreted by others.

Improving school staff's skills

This may be done by means of special training courses aimed at improving communication between distressed and/or suicidal students and their teachers, and enhancing awareness and understanding of suicide risk. Training all school staff in the capacity to talk among themselves and with the students about life and death issues, improving their skills in identifying distress, depression and suicidal behaviour, and increasing their knowledge about available support are crucial means of suicide prevention.

Clear goals and precise limits as defined in manuals on suicide prevention are important tools in this work.

Referral to professionals

A prompt, authoritative and decisive intervention, i.e. taking the suicidal young person to a general practitioner, a child psychiatrist or an emergency department, can be life-saving.

To be effective, youth health services need to be perceived as approachable, attractive and non-stigmatizing. Distressed and/or suicidal students should be actively and personally referred by school staff, and received by a team composed of doctors, nurses, social workers and legal representatives whose task is to protect the child's rights. This active transfer of the student to the health care system prevents her or him from dropping out during the referral process, which might happen if the referral is conducted only by correspondence.

Removing means of suicide from distressed and suicidal children's and adolescents' proximity

Various forms of supervision and removal or locking-up of dangerous medicines, guns, firearms, pesticides, explosives, knives, and so forth in schools, parental homes and other premises are very

important life-saving measures. Since these measures alone are not enough to prevent suicide in the long run, psychological support should be offered at the same time.

When suicide has been attempted or committed

Informing school staff and schoolmates

Schools need to have emergency plans on how to inform school staff, especially teachers, and also fellow pupils and parents, when suicide has been attempted or committed at school, the aim being to prevent a cluster of suicides. The contagion effect results from suicidal children's and adolescents' tendency to identify with destructive solutions adopted by people who have attempted or committed suicide. Recommendations on how to manage and prevent suicide clusters, developed and promulgated by the US Centers for Disease Control in 1994 are now in wide use.[27]

It is important to identify all suicidal students, both in the same class and in others. A suicide cluster, however, may involve not just children or adolescents who know one another: even young people who are far removed from or entirely unknown to suicide victims may identify with their behaviour and resort to suicide as a result.

Schoolmates, school staff and parents should be properly informed about a student's suicide or attempted suicide and the distress caused by such an act should be worked through.

SUMMARY OF RECOMMENDATIONS

Suicide is not an incomprehensible bolt from the blue: suicidal students give people around them enough warnings and scope to intervene. In suicide prevention work, teachers and other school staff face a challenge of great strategic importance, in which it is fundamental:

- to identify students with personality disturbances and offer them psychological support;
- to forge closer bonds with young people by talking to them and trying to understand and help;
- to alleviate mental distress;
- to be observant of and trained in the early recognition of suicidal communication whether through verbal statements and/or behavioural changes;
- to help less skilful students with their school work;
- to be observant of truancy;
- to destigmatize mental illness and help to eliminate misuse of alcohol and drugs;
- to refer students for treatment of psychiatric disorders and alcohol and drug abuse;
- to restrict students' access to means of suicide - toxic and lethal drugs, pesticides, firearms and other weapons, etc.;
- to give teachers and other school personnel on-the-spot access to means of alleviating their stress at work.

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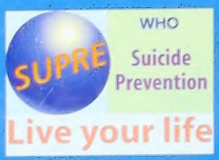

Preventing Suicide: a resource series

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2. A resource for media professionals
3. A resource for teachers and other school staff
4. A resource for primary health care workers
5. A resource for prison officers
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